IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
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July 17, 2009

Kathy Prophet
Preferred Community Homes - Mallard
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Mallard, provider #13G032

Dear Ms. Prophet:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Mallard, which was conducted on July 15, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 30, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 30, 2009. If a request for informal dispute resolution is received after July 30, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MAC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G032	A. BUILDING _____ B. WING _____	07/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MALLARD	699 SOUTH OTTER MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Matt Hauser, QMRP Common abbreviations/symbols used in this report are: HRC - Human Rights Committee IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse NOS - Not Otherwise Specified PRN - As Needed QMRP - Qualified Mental Retardation Professional RN - Registered Nurse	W 000	RECEIVED JUL 30 2009 FACILITY STANDARDS "Preparation and implementation of this plan of correction does not constitute admission or agreement by Mallard Landing with the facts, findings or other statements as alleged by the state agency dated July 15, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Mallard Landing – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 1 of 3 individuals (Individual #2) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #2's 11/17/08 IPP stated he was a 47 year old male whose diagnoses included autistic disorder and severe mental retardation.	W 214	**W 214 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN** Individual #2's behavioral assessment has been revised, and now contains comprehensive and accurate information. All individual's behavioral assessments will be reviewed by the Behavioral specialist and the QMRP to ensure all contain accurate and comprehensive information by 8-31-09. Monitored-As needed Person Responsible- Behavioral Specialist, QMRP Completed- 8-31-09 See pen and ink revisions next page.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7-29-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 214	Continued From page 1 Individual #2's Behavioral Assessment, revised 6/2/09, stated he engaged in "Behavior that is Hurtful to Self," defined as hitting his head against walls or doors, hitting/slapping his head so that is seen and heard, biting his fingers, poking his chest, and repetitively hitting his shin with the other heal, causing a visible injury. Under the "Function" section of the Behavioral Assessment, it stated all of Individual #2's maladaptive behaviors were "a result of his sensory needs and they are self stimulating behavior related to his diagnosis of autistic disorder." However, Individual #2's Training Program to address maladaptive behaviors included a replacement behavior for "Hurtful to Self" that stated he would "express his wants or needs." The replacement behavior was not consistent with the function of the behavior as defined by his Behavioral Assessment. When asked during an interview on 7/15/09 from 10:00 a.m. - 12:30 p.m., the Administrator stated Individual #2 engaged in repetitive, stereotypical behaviors related to his autism, but engaged in self injurious behavior when he was trying to communicate something such as pain, discomfort, or agitation. The Behavior Specialist, who was present during the interview, stated the Behavioral Assessment needed to be revised. The facility failed to ensure Individual #2's Behavioral Assessment contained comprehensive and accurate information.	W 214	Each individual will be reviewed at least quarterly at the psychiatric meetings. The Behavior Specialist will be in attendance, and any changes to individuals' behavioral needs will be discussed and the assessment revised as needed. - Per Kathy Prophet, Admin. by Michael Case, LSW on 7/30/09.	
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and	W 262		

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W 262	Continued From page 2 monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 3 of 3 individuals (Individuals #1 - #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include: 1. Individual #2's 11/17/08 IPP stated he was a 47 year old male whose diagnoses included autistic disorder and severe mental retardation. Individual #2's record contained the following consents for restrictive intervention: - The use of a papoose board for restraint during dental procedure, dated 4/10/09. - The use of Ambien (a sedative-hypnotic drug) for sleep disturbance, dated 4/10/09. - The use of Clonidine (an antihypertensive drug) for maladaptive behaviors, dated 4/10/09. - The use of Zyprexa (an antipsychotic drug) for maladaptive behaviors, dated 4/10/09. - The use of Zoloft (an antidepressant drug) for maladaptive behaviors, dated 4/10/09. - The use of Risperdal (an antipsychotic drug) for maladaptive behaviors, dated 4/10/09. - The use of Lorazepam (an anxiolytic drug) for dental appointments, dated 4/10/09. Individual #2's consents did not include	W 262	**W262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE** HRC approval has been obtained for individual #2's restrictive interventions, also for Individual #3's and Individual #1's PRN medication HRC has been obtained, a new system has been developed by the QMRP to ensure that all individuals consents are obtained one month before they are due. Monitored- monthly Person Responsible- QMRP Completed- 8-31-09	

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W 262	Continued From page 3 documentation of HRC approval. When asked during an interview on 7/15/09 from 10:00 a.m. - 12:30 p.m., the QMRP stated Individual #2's consents had not been presented to the HRC due to an oversight. When asked during a telephone interview on 7/16/09 from 4:10 - 4:15 p.m., the RN stated Individual #2 was receiving Ambien, Clonidine, Zyprexa, Zoloft, Risperdal, and Lorazepam, and used a papoose board during dental treatment. The facility failed to ensure HRC approval for Individual #2's restrictive interventions was obtained prior to their implementation. 2. Individual #3's 2/13/09 IPP stated he was a 58 year old male whose diagnosis included intermittent explosive disorder, severe mental retardation, and seizure disorder. Individual #3's record contained the following consents for restrictive intervention: - The use of one-on-one staff to remain within arms length of Individual #3, 24 hours a day seven days a week, dated 5/11/09. - The use of Zyprexa (an antipsychotic drug) PRN for maladaptive behaviors, dated 5/13/09. - The use of Ativan (an anxiolytic drug) PRN for maladaptive behaviors, dated 5/13/09. Individual #3's consents documented HRC approval was not obtained until 5/21/09. When asked during an interview on 7/15/09 from 10:00 a.m. - 12:30 p.m., the QMRP stated Individual #3's consents had been presented to the HRC late due to an oversight.	W 262		

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W 262	Continued From page 4 When asked during a telephone interview on 7/16/09 from 4:10 - 4:15 p.m., the RN stated Individual #3's one-on-one staff was implemented on 5/11/09. The RN stated Individual #3 had received PRN Zyprexa twice since 5/11/09, but had not yet received PRN Ativan for behavioral purposes. The facility failed to ensure HRC approval for Individual #3's restrictive interventions was obtained prior to their implementation. 3. Individual #1's IPP, dated 12/18/08, documented a 53 year old female diagnosed with moderate mental retardation, psychotic disorder NOS, and depressive disorder NOS. Individual #1's record included a document titled "Guidelines for Ativan PRN," dated 7/18/08, which stated she received Ativan (an antianxiety drug) PRN for "non-stop talking with negative comments, verbally targeting other clients, becoming increasingly physically active with the inability to sit still, and attempting to elope." Individual #1's record did not include documentation of HRC approval for Ativan. When asked during an interview on 7/15/09 at 2:50 p.m., the QMRP stated Individual #1's consent for Ativan had not been approved by the HRC due to an oversight. When asked during a telephone interview on 7/16/09 from 4:10 - 4:15 p.m., the RN stated Individual #1 had received PRN Ativan for behavioral purposes.	W 262		

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W 262	Continued From page 5 The facility failed to ensure HRC approval for Individual #1's Ativan was obtained prior to its implementation.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the guardian for 1 of 3 individuals (Individual #1) whose behavioral interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of a restrictive intervention. The findings include: 1. Individual #1's IPP, dated 12/18/08, documented a 53 year old female diagnosed with moderate mental retardation, psychotic disorder NOS, and depressive disorder NOS. Individual #1's record included a document titled "Guidelines for Ativan PRN," dated 7/18/08, which stated she received Ativan (an antianxiety drug) PRN for "non-stop talking with negative comments, verbally targeting other clients, becoming increasingly physically active with the inability to sit still, and attempting to elope." Individual #1's record did not include documentation of guardian consent for Ativan.	W 263	**W263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE** Individual #1's medication Ativan guardians consent has been obtained, a new system has been developed by the QMRP to ensure that all individuals consents are obtained one month before they are due, and verbal consents will be obtained by both HRC and the guardians prior to them being mailed out. Monitored- monthly Person Responsible- QMRP Completed- 8-31-09	

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W 263	Continued From page 6 When asked during an interview on 7/15/09 at 2:50 p.m., the QMRP stated consent for Individual #1's Ativan had not been obtained due to an oversight. When asked during a telephone interview on 7/16/09 from 4:10 - 4:15 p.m., the RN stated Individual #1 had received PRN Ativan for behavioral purposes. The facility failed to ensure guardian consent for Individual #1's Ativan was obtained prior to administering the drug.	W 263		
W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the use of restraint was documented to present a clear understanding of the events prior to, during, and following its use for 1 of 3 individuals (Individual #2) for whom restraint was used. Failure to keep a comprehensive record of restraint usage would not allow individual's IDT to make informed decisions and/or recommendations regarding the use of the restraint. The findings include: 1. Individual #2's 11/17/08 IPP stated he was a 47 year old male whose diagnoses included autistic disorder and severe mental retardation. Individual #2's record contained a Written Informed Consent, dated 4/10/09, which stated he required the use of a papoose board for dental procedures. The Written Informed Consent	W 303	**W303 483.450(d)(4) PHYSICAL RESTRAINTS** A comprehensive record of restraint has been developed and in place for individual #2's medical record. All individuals will be using this same record of restraint to ensure proper documentation is taking place. Record of restraints will be included in med records. Records include date, procedures, time in, time out, head supporting and reduction attempts. Monitored-as needed- audited monthly by RN Person Responsible- RN Completed- 8-31-09	

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W 303	Continued From page 7 stated the papoose board had "Velcro wraps which helps immobilize the arms and legs during the dental appointments." Individual #2's Dental Record included two entries, dated 11/11/08 and 5/12/09. Both entries stated "Pap board." However, no additional information regarding how the papoose board was used or the length of time Individual #2 was in the papoose board was present. When asked during an interview on 7/15/09 from 10:00 a.m. - 12:30 p.m., the RN stated a record of restraint should have been included with the dental note but was not. The facility failed to ensure a comprehensive record of restraint usage was kept.	W 303		
W 324	483.460(a)(3)(ii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure immunizations as recommended by the Public Health Service Advisory Committee were provided for 1 of 3 individuals (Individual #2) whose records were reviewed. This resulted in the potential for preventable illness to occur. Findings include:	W 324	**W324 483.460(a)(3)(ii) PHYSICIAN SERVICES** Individual #2 received his Tetanus shot and diphtheria booster on 7-14-09. The facility will conduct a chart audit to ensure all clients' immunizations are current. The facility will ensure immunizations are recorded as ordered by physicians. The RN will conduct an audit of immunization records and physician orders on a quarterly basis. Monitored-quarterly Person responsible-RN Completed- 8-31-09	

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W 324	Continued From page 8 1. Individual #2's 11/17/08 IPP stated he was a 47 year old male whose diagnoses included autistic disorder and severe mental retardation. Individual #2's Immunization and Inoculations record documented his last tetanus and diphtheria booster was received 11/10/98. Additionally, his record contained an Immunization Record Verification sheet, dated 9/4/07 and signed by the physician, which stated a tetanus booster was recommended. No additional documentation regarding a tetanus and diphtheria booster was present. When asked during an interview on 7/15/09 from 10:00 a.m. - 12:30 p.m., the RN stated Individual #2 had not received a tetanus and diphtheria booster due to an oversight. The facility failed to obtain recommended immunizations to ensure the health of Individual #2.	W 324		
W 325	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a routine screening laboratory examinations were provided to 1 of 3 individuals (Individual #2) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include:	W 325	**W325 483.460(a)(3)(iii) PHYSICIAN SERVICES** Individual #2 will have a cholesterol screening with his next lab which is scheduled for 7-31-09. All PCH clients over the age of 21 are affected per CDC guidelines. All adults over the age of 21 will have cholesterol screening every 5 years. The facility will audit the medical record of all clients over the age of 21 to ensure cholesterol screenings are obtained as per current CDC guidelines. The RN will audit all client charts on a quarterly basis- the audit will include review of lab reports and ensure cholesterol screenings are completed. Monitored-quarterly Person Responsible-RN Completed- 8-31-09	

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W 325	Continued From page 9 1. Individual #2's 11/17/08 IPP stated he was a 47 year old male whose diagnoses included autistic disorder and severe mental retardation. Individual #2's medical record was reviewed and showed routine blood work had been completed on 9/25/08. However, a cholesterol screening was not included. Individual #2's record did not contain any information regarding cholesterol screening. When asked during an interview on 7/15/09 from 10:00 a.m. - 12:30 p.m., the LPN stated she thought Individual #2's cholesterol screening had been completed but could not find a record that it had. The facility failed to ensure Individual #2 received standard laboratory screenings.	W 325		

Bureau of Facility Standards

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MM182	16.03.11.075.09 (a)(iv) Resident placed in Restraints The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following: A resident placed in restraint must be checked at least every thirty (30) minutes by appropriately trained staff and an account of this surveillance must be kept; and This Rule is not met as evidenced by: Refer to W303.	MM182	**MM182 16.03.11.075.09(a)(iv) Resident placed in Restraints** **Refer to W303** RECEIVED JUL 30 2009 FACILITY STANDARDS	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**MM194 16.03.11.075.10(a) Approval of Human Rights Committee** **Refer to W262**	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	**MM196 16.03.11.075.10(c) Consent of Parent or Guardian** **Refer to W263**	
MM548	16.03.11.210.02(g) Immunization Record of immunizations; and This Rule is not met as evidenced by: Refer to W324.	MM548	**MM548 16.03.11.210.02(g) Immunization** **Refer to W234**	

Bureau of Facility Standards

Kathy Dunbar — Administrator — 7-29-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G032	A. BUILDING _____ B. WING _____	07/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MALLARI	699 SOUTH OTTER MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM730	Continued From page 1	MM730		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Refer to W214	
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750	MM750 16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations Refer to W325	